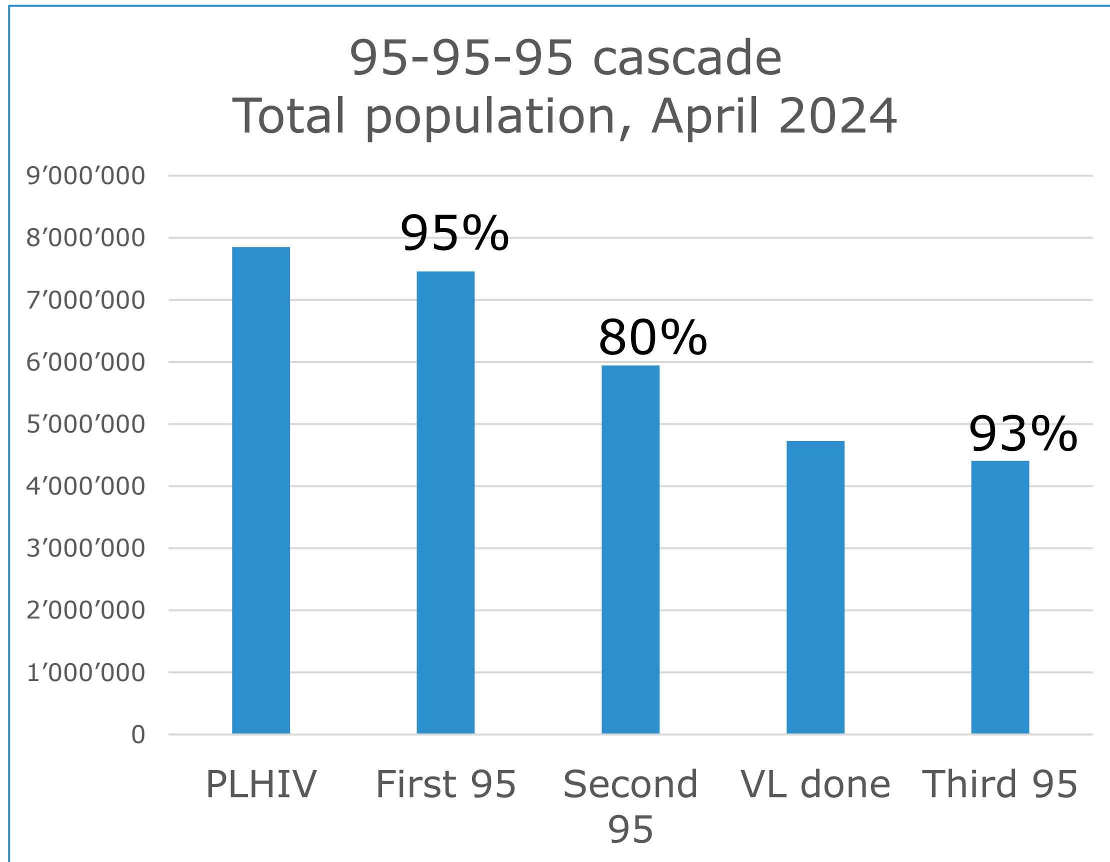
Musa Manganye, National Department of Health, South Africa

Differentiated strategies to support sustained engagement and re-engagement in HIV services in eastern and southern Africa

Differentiation at re-engagement: Considerations in building South Africa's re-engagement algorithm

South Africa's cascade is 95-80-93



Cascade figures vary by population

- Adult females: 96-84-94
- Adult males: 95-73-94
- Children (<15): 82-66-69

To achieve 95-95-95 targets, South Africa must increase the number of total clients on ART by **1,139,059**:

- Increase adult females on ART by **498,995**
- Increase adult males on ART by **565,177**
- Increase children (<15) on ART by **74,887**

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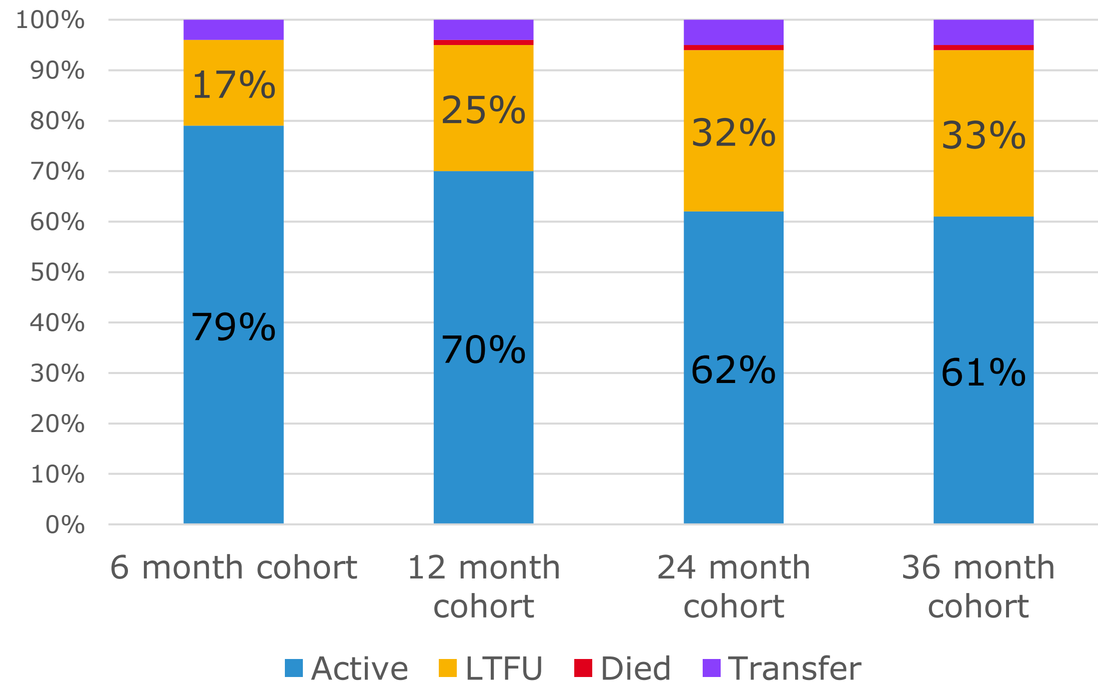
Two largest challenges: Sub-optimal 12-month retention and viral suppression



- 80% of cohort has a viral load done. Of those:
  - 907,658 have a VL 50-1000 copies/mL
  - 321,462 have a VL >1000 copies/mL
- 2023 Guideline update focused on 2nd and 3rd 90s – keeping people on treatment (especially in the first 12 months) and virally suppressed

Revised ART & differentiated models of care (DMOC) guidelines central approach

Aim 1: Implement optimized ART regimens

- Clinical updates

Aim 2: Create an enabling environment to support engagement in care and adherence

- Person-centred service delivery updates

- Updated clinical **and** service delivery guidance at the same time
- Coordinated national technical working group
- Reviewed previous re-engagement algorithm

DMOC and ART Clinical Guidelines assume full integrated approach in South Africa

- The first time **clinical** and **service delivery** guidelines were revised together to ensure coordinated approach to of both components of HIV care

Considerations for managing re-engaging clients

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1

For returning patients, the *first return visit experience* is critical

Welcoming, supportive and empathetic

Clear facility visit flow focused on a positive patient experience

2

***Not all patients* late for scheduled appointments are re-engaging patients**

Defined period

3

All re-engaging patients *DO NOT have* the same service delivery needs

Easier access to treatment

Psychosocial support

Clinical management

Always be kind

No judgement zone

Differentiation is critical – move away from a one size all approach for returning patients

Considerations for differentiation

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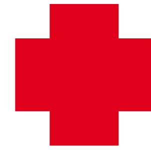
Clinical Factors



Duration since missed appointment

1. Clinical assessment

2. When to perform a CD4

3. When to perform a viral load

4. Regimen

1. Who to return immediately to Repeat Prescription collection strategies (RPCs = DSD)

2. Who to return to facility-based follow-up and appropriate refill length

Updated clinical + service delivery algorithm

Person returning to care after missed scheduled appointment date

Missed appointment ≤ **28 days**
+ self-identifies as well, and not on TB treatment

Routine care
Presents at:

RPCs model
(EX-PUP, FAC-PUP, Club)

Continue care in RPCs

Facility

Continue routine care.
Assess, offer and enrol in RPCs, if eligible

Missed appointment **> 28 days**
or self-identifies as unwell, or on TB treatment

Re-engagement

Perform clinical assessment
+ decide if enhanced adherence counselling (EAC) could assist*

EAC session 1
(see Annexure 3)

Presents clinically well

Missed appointment
29 - 90 days

Continue ART *(see **"Switching existing clients to DTG-containing regimens" on page 14**)* Assess for, offer, and enrol/re-enrol in RPCs

Missed appointment
> 90 days (LTF)

Unless there is a clinical indication to defer ART, restart ART on the same day (switch to TLD**, as outlined on ***"Switching existing clients to DTG-containing regimens" on page 14***
Do a CD4 count to identify AHD

3-month drug refill

Recall if CD4 ≤ 200

Presents clinically unwell, or with a prior high VL before treatment interruption, or has TB/HIV co-infection

Follow the HIV/ART and TB clinical guidelines as relevant

Clinical consult frequency as clinically indicated
Align drug refill length

If CD4 < 200:
Provide AHD package

***Clinician considerations for providing EAC session 1:**

1. Drug side effects impacting adherence? If yes and drug/s switched → no need for EAC
2. Difficulty getting to facility to collect treatment → no need for EAC
3. Challenges with taking/remembering to take treatment → provide EAC (see EAC SOP 2)

Perform VL monitoring as per ***"Routine HIV VL Monitoring on ART" on page 18 ******

VL assessment **3 months after re-engagement**
If VL suppressed, offer/re-enrol in RPCs

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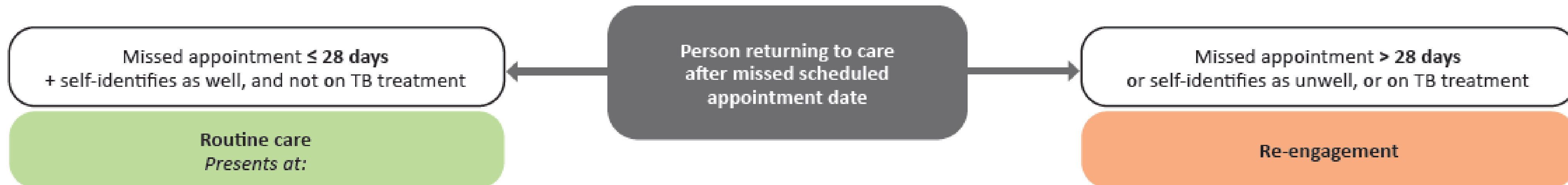
1. Clarifies returning clients are NOT ALL re-engaging clients

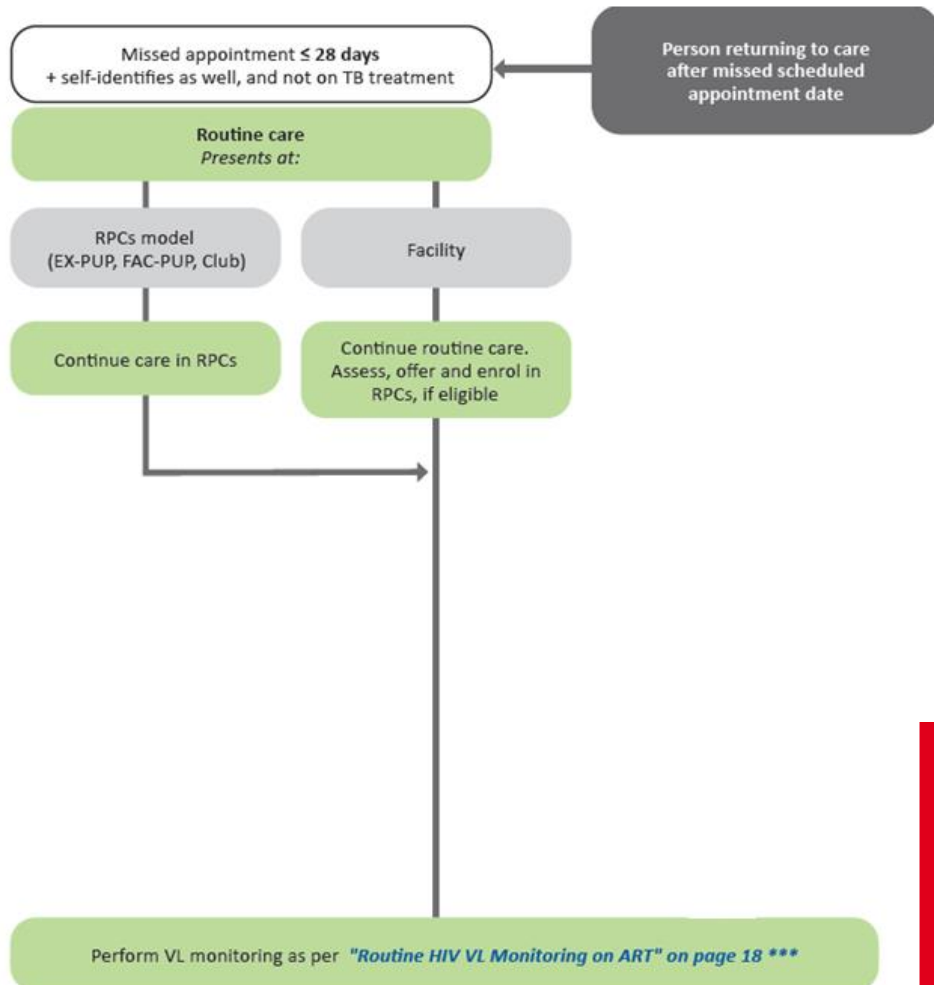


1. **If client not complaining of illness and less than 28 days late for appointment**
   - Continue in routine care
2. **If client complaining of illness or on TB treatment or more than 28 days late for appointment – needs to be seen by a clinician**
   - Manage as a re-engaging client

WHY?

- Support appointment flexibility rather than disengagement in era of DTG
- Reduce unnecessary burden/administration complexity on clients and health system

2. Returning to routine care includes staying in your RPCs



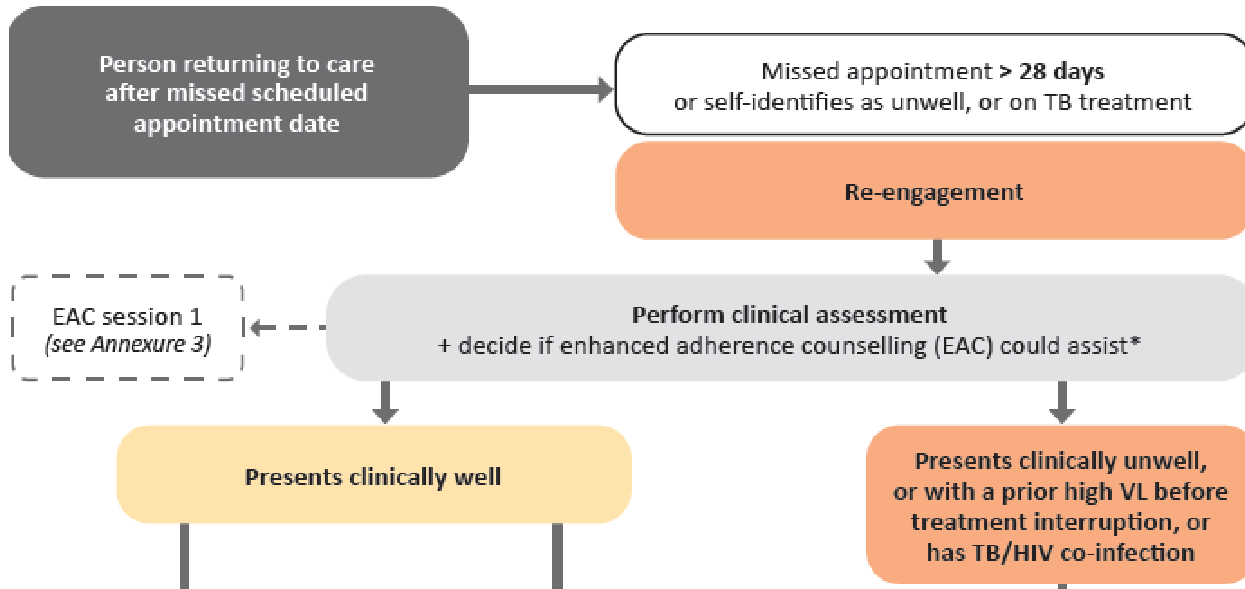
1. **If in RPCs – stay in RPCs**
2. **If not in RPCs – prioritize assessment for RPCs or rescript for RPCs**
   - Late for this appointment or previous appointments does not disqualify client BUT rather red flags for RPCs enrolment to reduce risk of disengagement

Consideration to note: supply chain complexities meant pre-packed ART could not remain at pick-up points for longer than 28 days

When do you do CD4 and VL?

- No repeat CD4
- Repeat VL as per annual schedule
  - For RPCs client - next scheduled RPCs clinical review with VL
- If VL overdue at return perform after back on ART for 3 months

3. Re-engaging clients management depends on clinical stability



***Clinician considerations for providing EAC session 1:**

1. Drug side effects impacting adherence? If yes and drug/s switched → no need for EAC
2. Difficulty getting to facility to collect treatment → no need for EAC
3. Challenges with taking/remembering to take treatment → provide EAC (see EAC SOP 2)

- **If return and self-identify as unwell, more than 28 days late or on TB treatment require a clinical assessment**
  - Check clinical presentation – decide if well or not?
  - Check last VL result
  - Check regimen – on TLD?
  - Assess if enhanced adherence counselling (EAC) useful. If yes, clinician to provide.
- **Differentiate again**
  - Unwell OR previous elevated VL OR on TB treatment
  - Well

WHY differentiate care?

- Most clients who disengaged need <u>less</u> intensive <u>not more</u> intensive follow-up to reduce risk of interrupting treatment again.
- **HOWEVER** minority do need more intensive clinical management

4. Client unwell, previous elevated VL or on TB treatment

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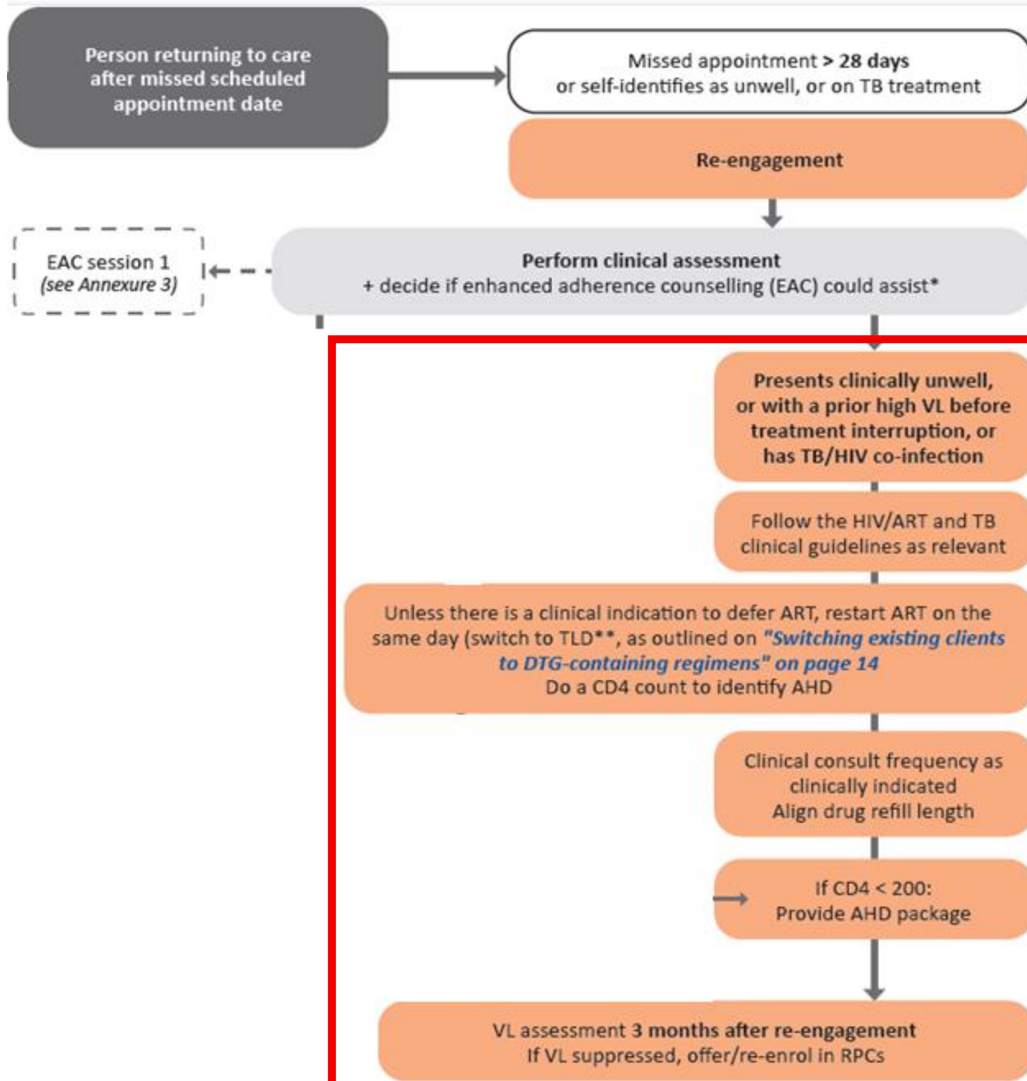
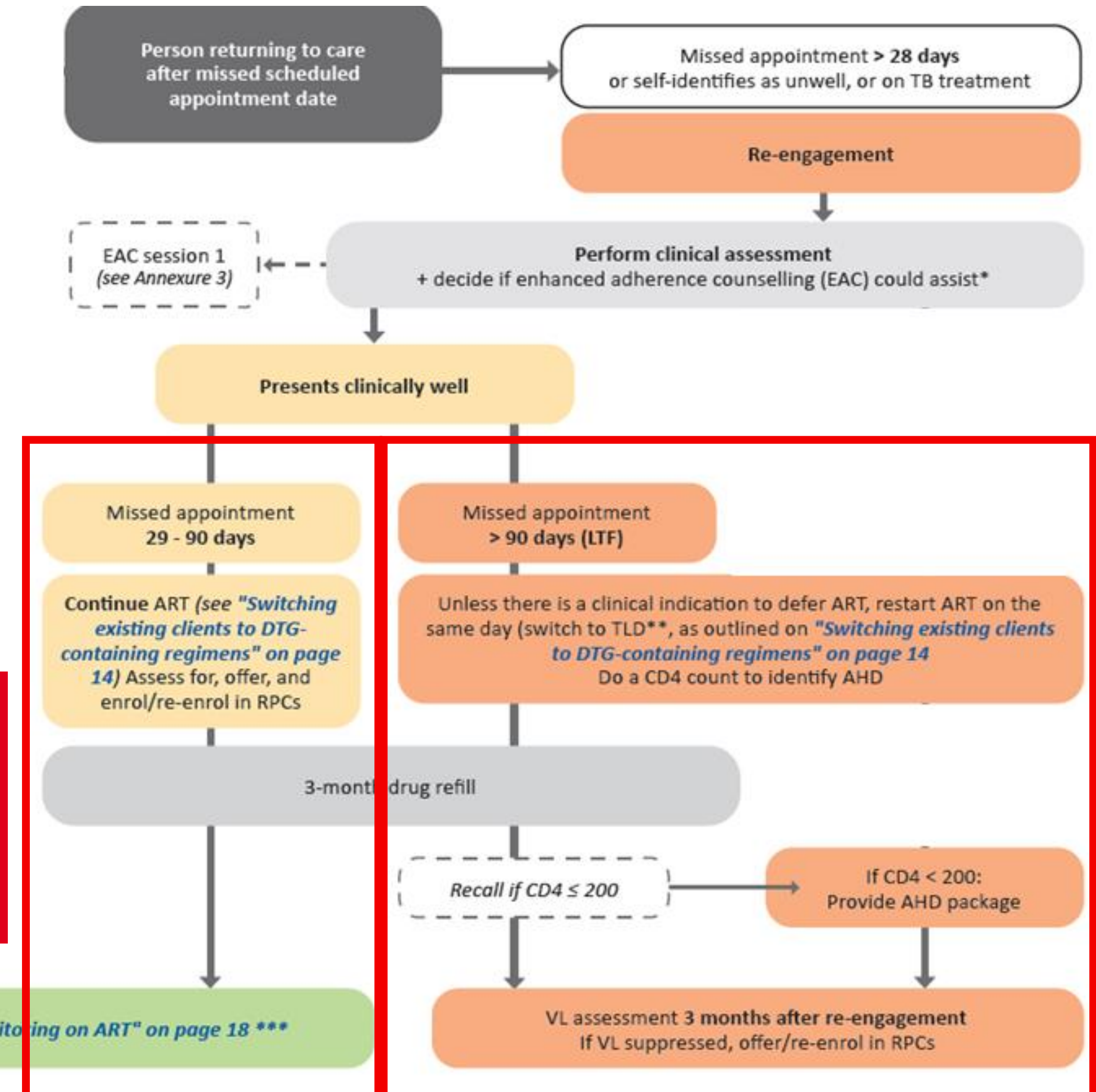


1. **Follow ART and TB guidelines for management of OIs**
2. **Restart ART same day* – switch if not on TLD**
3. **Take CD4 count – may now have AHD**
4. **Review CD4 count, if <200 - provide AHD screening and treatment package**
5. **VL assessment after 3 months**
6. **Do not have to see client each month until follow- up VL – clinician to decide:**
    - necessary clinical review frequency
    - align ART refills

5. Client well BUT >28 days late

1. 29-90 days late:
- No CD4, no additional VL
- Continue ART (switch if not on TLD)
- Assess for and offer RPCs or facility to provide 3 months of ART

2. More 90 days late (unconfirmed LTF)
- CD4 (recall if CD4<200 for AHD package)
- VL in 3 months time
- Facility to provide 3-months supply until VL date



<u>Note ONLY differences between ≤28 days (routine care) and >28 days (re-engagement):</u>
- Must get clinical assessment and possibly EAC
- Cannot collect ART in RPCs as prepacks will have been returned. Can be immediately rescripted for RPCs

Implementation to date and next steps

- **Training** –Clinicians, Non-Clinicians Trained on revised DSD SOPs Including SOP number 8 on Re-Engagement in all nine provinces.

- **Monitoring of implementation -** DSD Performance reviews conducted in all nine provinces (Data Abstractions) and routine implementation of SOP 8 and reporting

- **Evaluation**
  - DSD Performance reviews results reported back at disseminations workshops.
  - Research agenda to address the challenges on re-engagement (NDOH collaborating with HE2RO)

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Acknowledgements

- National Department of Health
- Provincial Department of Health
- Operation Phuthuma
- IAS
- District Support Partners
- ICAP- CQUIN
- Global Fund
- PEPFAR
- CDC
- USAID
- Learning Sites / Health Facilities

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Department:
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